COVID-19 Vaccine Registration Form MODERNA BIVALENT BOOSTER

SECTION 1

FIRST NAME	MIDDLE INITIAL	LAST NAME	CVX CODE	CPT CODE

DATE OF BIRTH / /	AGE	17 OR UNDER? ☐ Yes ☐ No	MISSED APPT ☐ Yes ☒ No	REFUSAL ☐ Yes ☒ No
PHONE NUMBER OK TO TEXT? Yes No	EMAIL OK TO EMAIL? Yes No			
STREET ADDRESS				

RACE
- ☐ Alaskan Native (5)
- ☐ American Indian (5)
- ☐ Asian (4)
- ☐ Black (2)
- ☐ Native Hawaiian (7)
- ☐ Pacific Islander (7)
- ☐ White (1)
- ☐ Other (6)
- ☐ Unknown (9)

ETHNICITY
- ☐ Hispanic/Latino (1)
- ☐ Not Hispanic/Latino (2)
- ☐ Unknown (3)

SEX
- ☐ Female (F)
- ☐ Male (M)
- ☐ Other (O)
- ☐ Unknown (U)

CITY	STATE	ZIP	COUNTY OF RESIDENCE

PATIENT QUESTIONS	
Have you ever had a severe allergic reaction to a vaccine or any injection in the past?	☐ No ☐ Yes
Have you tested positive for COVID-19 in the last two weeks?	☐ No ☐ Yes
Have you received antibody therapy (monoclonal or convalescent plasma) for COVID-19 in the last 3 months?	☐ No ☐ Yes
Do you have a weakened immune system (ie, from HIV or cancer) or are you on immunosuppressive drugs?	☐ No ☐ Yes
Do you have a bleeding disorder or are you taking a blood thinner?	☐ No ☐ Yes
Have you completed the initial Pfizer/Moderna monovalent series (1st and 2nd doses) at least 2 months ago?	☐ No ☐ Yes
If you received a Pfizer/Moderna monovalent booster, has it been at least 2 months ago?	☐ No ☐ Yes ☐ N/A
Please provide all prior COVID Vaccine Date(s) and Manufacturer:	

Please visit the CDC website cdc.gov/coronavirus/2019-ncov/vaccines/index.html to learn about the benefits and risks (VIS) of the COVID-19 vaccine. Please visit our website (posted at the clinic) to read our Privacy Policy (PP). By signing below, you agree that 1) you reviewed both the VIS and PP, 2) you understand the benefits and risks of the vaccine and you are asking that the vaccine be given to you or the person named on this form for whom you are authorized to make this request, 3) you hereby consent that we can bill your insurance, if applicable, 4) you authorize the release of this vaccination record and all information on this form to your state's Immunization Program and the CDC, and 5) we can release this record to your doctor, school, or employer if requested. If the person who is being vaccinated is age 17 or under, by signing below you agree that you are authorized to consent to the vaccination of the patient and the patient on this form may receive vaccine with or without you, as the parent or guardian, present at the time of vaccination. After receiving your vaccine, we recommend you wait at least 15 minutes. If you leave the vaccination site before 15 minutes has passed after your vaccination you assume any risks associated with not waiting the recommended amount of time.

PATIENT CONSENT/SIGNATURE (or parent/guardian if patient is age 17 or under)	DATE OF CONSENT / /

SECTION 2

OFFICE USE ONLY

VACCINE NAME	LOT NUMBER	EXPIRATION DATE	DOSE SIZE	MANUFACTURER
COVID-19			☐ Full (0.5mL)	Moderna Bivalent

ROUTE OF ADMIN	SITE OF INJECTION
☒ IM ☐ TD ☐ IV ☐ NS ☐ SC ☐ ID ☐ O ☐ Oth	☐ RA ☐ RD ☐ RT ☐ Other ☐ LA ☐ LD ☐ LT _____

VACCINATOR	NOTES	DATE OF VACCINATION / /

CLINIC LOCATION	CLINIC TYPE	CLINIC ADDRESS	STATE VACCINE SYSTEM DATA ENTRY
			☐ By clinic/agency GIVING vaccine (N) ☐ By clinic/agency NOT giving vaccine (Y)

Welcome Nursing Home Vaccination Acceptance or Refusal

In the enclosed letter you will find information from the CDC regarding the influenza (flu) vaccine which includes the contraindications, risks, and the benefits of receiving the vaccination. Please take the time to read this informational statement to help you make an informed decision.

As the resident or the resident's legal representative, you have a right to refuse the annual influenza (flu) vaccine. Nurses are available to answer any additional questions you may have.

Indicate your acceptance or refusal by circling **YES** or **NO** for the vaccine.

YES I will ACCEPT the seasonal influenza vaccine for the resident listed below.

NO I am REFUSING the seasonal influenza vaccine for the resident listed below after being educated on the benefits of the vaccine.

Resident Name _____
(Please Print)

Resident/POA _____ Date_____
Signature

Please read and sign. Please return this form as soon as possible. You may drop the form off at the receptionist desk or send via mail or email.

Welcome Nursing Home
417 South Main Street
Oberlin, OH 44074
ATTN: Sarah Stevens, DON/RN
sstevens@welcomenursinghome.com